QUARTERLY BULLETIN OF ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Spring
2008

Getting ready for Congress

The Annual Congress will be held from 20-22 May. Cyclists have the chance to celebrate our 20th Anniversary by cycling to Liverpool from the College departing 17 May. To book your seat contact Michael Quinn *mjquinn2002@yahoo.com* ASAP as numbers are limited. Funds raised will be used to help train ophthalmologists from developing countries. It should also be great fun for the participants.

There will be a SAS Group Forum on Tuesday, 20 May, 4.45–5.45 pm where College officers will be available to answer questions. Questions should be sent by 3 May to *sas@rcophth.ac.uk*

The Annual General Meeting will take place at 3.45 pm on Wednesday, 21 May and all members are eligible to attend. Those members who are not registered for Congress but wish to attend the AGM only must present themselves at the registration desk at 3.00– 3.30 pm so that a security pass can be made.

There will be an OTG Group Forum on Wednesday, 21 May, 5.15–6.15 pm where, again, College officers will be available to answer questions. Questions should be sent by 4 May to *otg@rcophth.ac.uk*

The 20th Anniversary Ball will be held on Wednesday evening from 7.30 pm Please register at *www.rcophth.ac.uk* We still need appealing items or experiences to auction during the Ball. So if you have a vacant week in a holiday home, tickets to an exclusive event or any other desirable, auctionable commodity please contact *soozmollan@doctors.org.uk* Funds raised will be used to help train ophthalmologists from developing countries.

The President, Brenda Billington, presenting Professor Ian Rennie, the outgoing editor of Eye with a commemorative cover of the journal after the December Council.

Development on the E-Learning project with the Department of Health are expected. Please visit *www.rcophth.ac.uk* for updates

Articles and information to be considered for publication should be sent to:
kathy.evans@rcophth.ac.uk
and advertising queries should be directed to:
Robert Sloan 020 8882 7199
rsloan@rsa2.demon.co.uk

Copy deadlines

Summer	5 May 08
Autumn	5 August 08
Winter	5 November 08
Spring	5 February 09

Regional Advisers

Regional advisers are appointed by Council to act on behalf of the College. They must be both:

- Fellows of the Royal College of Ophthalmologists registered with the College for Continuing Professional Development (CPD).
- NHS consultants with an established or honorary contract in active practice. Advisers must stand down on retirement from their NHS post.

The table below shows those post holders who will complete a three-year term of office from June 2008. In most cases they are eligible to stand for re-election for a second and final term. Any person wishing to stand should contact *Hon.Sec@rcophth.ac.uk*

REGION	CURRENT POST HOLDERS	DATE OF RETIREMENT	ELIGIBLE FOR RE-ELECTION
Northern	Mr Robert Allchin	June 2008	No
Leicester/Northampton & Rutland Deanery	Mr Geoffrey Woodruff	June 2008	Yes
Nottingham/Mansfield Derby & Chesterfield Deanery	Mr Richard Gregson	June 2008	Yes
East Anglia	Mr Simon Hardman Lea	September 2008	Yes
South Yorkshire & South Humberside	Mr Tin Chan	December 2008	Yes
South Western	Mr Anthony Quinn	December 2008	Yes
Mersey	Mr Mark Watts	December 2008	Yes
Scotland West (Glasgow)	Dr Charles Diaper	December 2008	Yes

The Part 2 FRCOphth Examination

The new examination structure continues to evolve under the guidance of PMETB. The first Part 1 FRCOphth examination was held in October 2006 and the first Refraction Certificate was held in July 2007.

The first Part 2 FRCOphth written examination will take place in September in London and the practical/clinical component will be held in October in Birmingham.

Eligibility

This examination will be open to candidates who have passed the Part 1 FRCOphth and the Refraction Certificate. This is an exit level assessment. There is no specific training requirement but candidates are unlikely to successfully complete this examination without a significant period of training in ophthalmology.

This new exam structure is de-coupled from Ophthalmic Specialist Training and is therefore open to all, not just those in OST. However, the examination is a necessary but insufficient requirement for completion of OST and the award of a certificate of completion of training (CCT). Specialty registrars therefore will be required to pass this examination by the end of year **seven** of ophthalmic specialist training.

Structure

The Part 2 FRCOphth examination consists of:

- Written papers (single best answer multiple choice and extended matching questions)
- Structured viva
- Objective structured clinical examinations (OSCE).

The syllabus covers all areas of the RCOphth OST curriculum.

Further details are available on the College website at: *www.rcophth.ac.uk/exams*

Laser refractive surgery assessments

There will be an assessment in London on 13-14 October 2008 (closing date 18 August).

Candidates will only have to attend one day. Successful candidates will receive a certificate of competence to practise, which will be subject to satisfactory yearly appraisals and continuing professional development. This certificate applies only to refractive procedures performed by laser.

Full details can be found at *http://www.rcophth.ac.uk/exams/laser-refractive-surgery*

Editor of Focus - vacancy

Mr William Newman has edited Focus since Spring 2005 and *Antibiotic prophylaxis of post-operative endophthalmitis in cataract surgery* (pages 5 and 6) will be the last topic to receive his care and attention. The College, particularly the Scientific Committee, would like to thank him for his hard work. This has created a vacancy which would suit an ophthalmologist who is conversant with current scientific and practice issues, a good writer and able to meet deadlines. Interested members should contact *kathy.evans@rcophth.ac.uk* by 10 April 2008

The 2008 Ruskell Medal

The Ruskell Medal and a prize of £750 is given by the Worshipful Company of Spectacle Makers, in honour of the late Professor Gordon Ruskell. It is directed at those making their initial "first author" published contribution to the advancement of basic, clinical or technical ophthalmic science. Entries are invited from persons holding a first degree, diploma or other acceptable qualification obtained within three years preceding the closing date of 28th March 2008. Further details are available at *www.rcophth.ac.uk/about/college/ruskell-medal*

John Winstanley MC TD FRCS FRCOphth 1919- 2008

John Winstanley was educated at Wellington College and, in 1938, entered St.Thomas' Hospital in London to study medicine. However, these studies were interrupted by the outbreak of the Second World War, throughout the whole of which he served as an infantry officer with the Royal West Kent Regiment. In 1944 he was awarded the Military Cross for valour at the battle of the tunnels at Arakan and he also fought at the famous Battle of Kohima –one of the first actions in Burma to resist the Japanese advance.

He returned to medical studies in 1945 and qualified in 1951. He underwent his ophthalmic training at Moorfields Eye Hospital and was appointed Consultant Ophthalmologist to St.Thomas' and to the Lewisham and Greenwich Hospitals in 1960. He retired in 1983. In earlier days he and the inspirational Harold Ridley were a formidable combination in the eye department of St.Thomas'.

John was a reliable and consistent surgeon and no patient that he saw had less than a meticulous examination. He was an excellent teacher, particularly of medical students, and he encouraged numerous St.Thomas' graduates in their ophthalmic careers.

He was Honorary Surgeon to the Royal Hospital Chelsea and Civilian Consultant in Ophthalmology to the Army and to the Metropolitan Police. He was an examiner in Ophthalmology to the Royal College of Surgeons and was Vice President of the Ophthalmic Section of the Royal Society of Medicine, of the Faculty of Ophthalmologists, and of the Ophthalmological Society of the United Kingdom. He served on the Council of the Medical Protection Society for many years.

Outside medicine his interests were varied and pursued with great enthusiasm and humour – he had a love of field sports especially fly-fishing, and he was a keen collector of sporting, military and ophthalmic memorabilia. The Royal College of Ophthalmologists was grateful to have acquired some of his antiquarian ophthalmic books.
He will be much missed by his family and a wide circle of friends and colleagues.

Anthony Chignell

Obituary

We note with regret the deaths of:
Dr Fiona Dolan – Glasgow
Professor David Hill - London
Mr John Howe – Newcastle-upon-Tyne
Dr T H Laxmi - Stockport
Mr Karamjit Singh Toor - Wakefield

The Staff and Associate Specialists Ophthalmologists' Group (SAS) was established in the autumn of 2006 and now meets three times a year.

Committee members have been in communication with ophthalmology departments around the UK to try to contact all SAS ophthalmologists. They have succeeded in collecting email addresses for many, but if you are reading this and have not been contacted, please get in touch with your regional representative via *sas@rcophth.ac.uk* .

Email

We continue to urge all members who have not already done so to email ***database@rcophth.ac.uk*** with their email address so that we can contact the whole membership electronically. Please note that we can only store one email address.

Consultant Appointments

Mr John S Barry	Birmingham Childrens' Hospital, Birmingham
Mr David Cheung	Sandwell General Hospital, West Bromwich
Mr John Fuller	Dorset County Hospital, Dorchester
Dr Alaeddin Hatoum	Queen Elizabeth Hospital, King's Lynn
Miss Lucy Howe	Dorset County Hospital, Dorchester
Mr Damian Lake	Queen Victoria Hospital, East Grinstead
Mr James Kersey	The Royal Bournemouth Hospital, Dorset
Mr Shabbir Mohamed	Birmingham and Midland Eye Centre, Birmingham
Mr Niall Patton	Royal Hallamshire Hospital, Sheffield
Dr Aravind Reddy	Aberdeen Royal Infirmary, Aberdeen
Mr Sathish Srinivasan	Ayr Hospital, Ayr
Mr Kuan Tzen Sim	Wycombe General Hospital, Aylesbury, Bucks
Mr Richard Wintle	West Wales General Hospital, Carmarthen

Miss Heidi Chittenden was appointed as a Consultant in Ophthalmology in the Defence Medical Services in November 2005 and was subsequently appointed to a Consultant post at Ashford & St Peter's Hospitals NHS Trust, Chertsy, in September 2006.

Connecting for Health (CfH) has made the following appointments, on a part time seconded basis for two years:
Miss Parul Desai - National Clinical Lead for Public Health, having responsibility for bringing together the data collected by the NHS and other organisations, in order to maximise its value for better delivery of healthcare, clinical practice and its application for the Secondary Uses Service (SUS) and clinical research.
Mr John Sparrow - National Clinical Lead for Ophthalmology - having responsibility for ophthalmology as a CfH exemplar speciality, including development of datasets and an electronic ophthalmological dataset portfolio.

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Spring
2008

An occasional update commissioned by the College. The views expressed are those of the author.

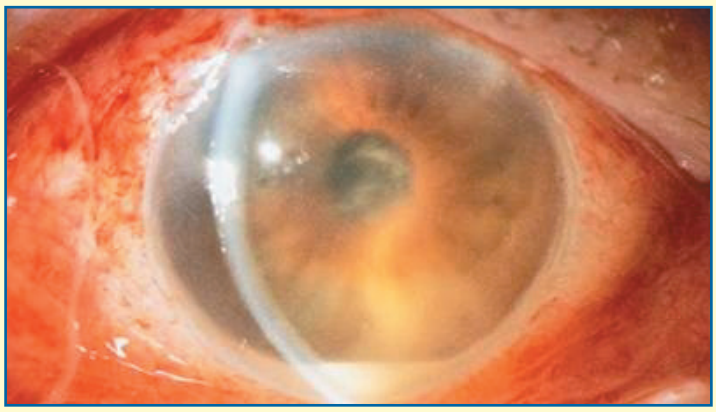
Antibiotic prophylaxis of post-operative endophthalmitis in cataract surgery

Post-operative endophthalmitis (PE) is a rare but dreaded complication of cataract surgery. The evidence suggests that it arises when bacterial flora from the lids and conjunctiva are introduced into the anterior chamber either at the time of surgery or in the early post-operative period. Current strategies for endophthalmitis prophylaxis focus on eliminating conjuctival bacteria with peri-operative topical antibiotics and antiseptics and on inhibiting the proliferation of microorganisms that have gained access to the anterior chamber through the use of high dose intracameral or subconjunctival bactericidal antibiotics.

A survey of 800 consultant ophthalmologists' practices in the UK conducted between October and November 2005 revealed the following preferences for antibiotic prophylaxis of PE: subconjunctival antibiotics 77%, intracameral antibiotics 17%, and single dose topical antibiotics 17%.[1] It is likely that prescribing patterns of antibiotic prophylaxis for PE will change in the near future in the light of recent developments in this field.

Intracameral antibiotics

In March 2006, the interim results of a prospective randomised controlled trial of intracameral cefuroxime for PE prophylaxis following cataract surgery were fast-tracked to publication owing to the significance of the findings.[2] In this study, which involved 24 centres in nine countries in Europe, 16,603 patients were randomised to receive one of four prophylactic regimens prior to cataract surgery: 1) no antibiotics, 2) intracameral cefuroxime 1mg in 0.1ml normal saline as a bolus injection at the end of surgery, 3) a topical regime of levofloxacin 0.5% starting 1 hour pre-operatively, or 4) a combination of intracameral cefuroxime and levofloxacin drops. All patients received a 6-day course of topical levofloxacin post-operatively. Final data analysis revealed that the absence of intracameral cefuroxime was associated with a 4.92-fold increase (95% confidence interval [CI], 1.87-12.9) in the risk of total PE (proven and suspected) and an even larger increase in risk for confirmed cases. The incidence rates for total PE was 0.35% when no antibiotic prophylaxis was given (background rate), reducing to below 0.08% with the use of intracameral cefuroxime. Thus, the findings of this landmark study give resounding support to the use of intracameral cefuroxime for PE prophylaxis in cataract surgery.



Are there any limitations to the use of intracameral cefuroxime as endophthalmitis prophylaxis in cataract surgery?

The adverse effects of this treatment have not been fully elucidated to date, although it appears to have minimal effect on corneal endothelial function and post-operative macular thickness based on available evidence.[3] Hypersensitivity reactions to cefuroxime appear to be extremely rare but cross-reactivity between penicillin and the cephalosporins is a cause for concern and intracameral cephalosporin-induced anaphylaxis has been reported.[4] The potential for dosage errors and the introduction of contaminants into the eye also exists, especially if the drug is prepared for injection in the operating theatre rather than a sterile pharmacy. Cefuroxime reconstituted in normal saline becomes unstable after 24 hours at room temperature and after seven days when frozen so there is a degree of inconvenience attached to its use.4 At present, a single dose sterile preparation of cefuroxime is not commercially available.

Perhaps the greatest limitation of cefuroxime as the choice of antibiotic for PE prophylaxis relates to its spectrum of activity. As a third generation cephalosporin it has much better gram negative cover than first generation agents like cefazolin,

but at the expense of its gram positive potency. Since the widespread use of intracameral cefuroxime in Sweden, the proportion of cases of PE due to cefuroxime resistant organisms has increased from 7% to 60% in Sweden, with enterococcus accounting for a staggering 25% of cases compared to only 2% in the Endophthalmitis Vitrectomy Study.[5] Although cefazolin lacks sufficient gram negative potency, it is probably better suited to the microbial spectrum seen in PE than cefuroxime, which according to most reports is 90-100% gram positive. Two retrospective observational studies from Spain have reported marked reductions in PE rates with the use of intracameral cefazolin of the same order of magnitude as the ESCRS study.[6,7]

Vancomycin has been a popular choice for intraclameral delivery during cataract surgery since the early 1990s and offers an alternative to the cephalosporins. It is a bactericidal antibiotic with 100% coverage of gram positive PE-causing organisms. Furthermore, it is the only antibiotic that has been shown to maintain bactericidal levels in the anterior chamber for in excess of 24 hours following intracameral bolus injection, although there is no definitive evidence that it protects against PE.[8] The addition of vancomycin to the irrigating fluid during cataract surgery is a practice that should be abandoned as it has been shown to have no significant effect on the incidence rate of PE or aqueous contamination after cataract surgery and it fails to achieve sustained bactericidal levels of antibiotic in the anterior chamber. The potential for contributing to vancomycin resistance through its prophylactic use is a significant concern and both the American Academy of Ophthalmology and the Centers for Disease Control and Prevention in the USA advise against its use in cataract surgery.

The fluoroquinolones are bactericidal antibiotics with broad spectrum activity against gram positive and gram negative infections. As increasing resistance in ocular bacterial isolates to the second generation agents ciprofloxacin and ofloxacin is becoming apparent, in particular against enterococcus, coagulase negative staphylococcus and streptococcal species, the third generation agent levofloxacin and the fourth generation agents moxifloxacin and gatifloxacin are being more widely used. Although no published data exist to support the efficacy of intracameral moxifloxacin in PE prophylaxis, at high intracameral concentrations its coverage of gram postive infections might be comparable to vancomycin. It shows excellent in vitro activity against ocular gram positive and gram negative isolates.[4] Another potential advantage of moxifloxacin is that it is available in a single dose self-preserved preparation (Vigamox, Alcon) that appears to have no deleterious effect on the corneal endothelium following cataract surgery.[9] Moxifloxacin is not currently licensed for ophthalmic use in the European Union but is due to be approved in the near future.

Subconjunctival antibiotics

Subconjunctival antibiotics, in particular cefuroxime and gentamicin, are popular for PE prophylaxis in the UK.1 Kamalarajah and colleagues, on behalf of the British Ophthalmological Surveillance Unit (BOSU), found in a prospective case-control study of 214 cases of presumed PE following cataract surgery that the administration of subconjunctival antibiotics (gentamicin or cefuroxime) at the end of cataract surgery protected against PE (odds ratio 0.18, confidence interval 0.09-0.36).[10] In a retrospective population-based case-control study of 205 cases of PE in Western Australia from 1980 to 2000, Ng et al found that subconjunctival antibiotics reduced the risk of PE by 54%.[11] Thus, it appears on the basis of this evidence that subconjunctival antibiotics confer some protection against PE.

Topical antibiotics

In contrast to the small percentage of ophthalmologists in the UK using pre-operative topical antibiotics for cataract surgery (6%), this is an almost universal practice in the United States in spite of the lack of supporting evidence. A recent survey of members of the American Society of Cataract and Refractive Surgery revealed that 52% of cataract surgeons prescribe three days of pre-operative antibiotic drops, 20% give drops one day pre-operatively and 22% administer them pre-operatively on the day of surgery.[12]

Moshirafar and colleagues in the United States reported a PE incidence rate of 0.07% in a retrospective uncontrolled multi-centre observational series of approximately 16,000 patients undergoing uncomplicated cataract surgery who received a topical regimen of gatifloxacin or moxifloxacin starting one hour pre-operatively.[13] As the study was uncontrolled it was not possible to definitively attribute the low PE rate to the use of prophylactic topical antibiotics. Of note, in the ESCRS study the use of levofloxacin drops 0.5% starting one hour pre-operatively was not found to sigificantly reduce the risk of PE (incidence rate 0.25% vs. 0.35% with placebo) and no other prospective controlled clinical trials of topical antibiotic prophylaxis of PE have been published to date.

Although it was not designed to evaluate the effectiveness of using levofloxacin drops post-operatively to prevent PE, the high incidence of PE in the two groups not receiving intracameral cefuroxime (approximately 1:300) suggested that there was little benefit in using post-operative antibiotics. Indeed, there is no evidence to support the use of topical antibiotics following cataract surgery in spite of their almost universal use.

Conclusion

The evidence regarding antibiotic prophylaxis of PE in cataract surgery strongly supports the use of intracameral cefuroxime. However, it is not without its limitations and arguably if a department has a PE rate of lower than that achieved with intracameral cefuroxime in the ESCRS study, continuing with less evidence-based strategies might be justified. Without doubt, the strength of the evidence presented supports at a very minimum the use of subconjuctival antibiotics in all cases, particularly in view of the high incidence rate of PE without any prophylaxis as demonstrated in the ESCRS study. At present the evidence for topical antibiotic prophylaxis is weak, but the fourth generation fluoroquinolone moxifloxacin appears to offer an excellent alternative to cefuroxime, either in topical or intracameral form, and further prospective controlled trials are required to investigate its efficacy and safety in PE prevention. The continuing emergence of multi-drug resistant bacteria will ensure that antibiotic prophylaxis of post-operative endophthalmitis remains an active area of investigation.

Conor Murphy, PhD FRCOphth
St. Paul's Eye Unit, Royal Liverpool University Hospital, Liverpool.

References can be found at http://www.rcophth.ac.uk/scientific/focus

Museum Piece

ORIGIN OF THE TRIAL CASE

There are many illustrations and paintings depicting itinerant pedlars of eyeglasses in the 17th century. This was the first method of obtaining glasses by self selection but the claim for the first trial lens could well be attributed to Johann Zahn (1641-1707) who constructed a polyspherical lens mounted on a handle in 1685. Each of the six circles represents a different convex power. (Photograph by kind permission of the Royal Astronomical Society)

In 1838 George Cox, an instrument maker, was the first to construct a form of testing set consisting of eight or nine pairs of lenses in frame fronts screwed together at one end to form a box.

The first "case" of trial lenses is attributed to Georg Fronmuller of Furst (1809-1899) in 1843. In describing his invention he states: "I have gathered together in one case for my own use the necessary kinds of concave and convex glasses, in all about 60 pairs, arranged according to their serial numbers so that they can be easily found. Further I have prepared an eyeglass frame in which the glasses can be placed at will and again removed. In this way I have obtained the advantage of adding glasses of different form for the right and left eye which is frequently necessary."

Fronmuller added that he produced this case specifically with the intention of preventing sight testing by anyone other than a medical refractionist. He cited the case of a man he knew who wore a bifocal spectacle..."a certain means of ruining the eyes sooner or later"!

The illustration is of a very early example of a trial case and trial frame. The case was found in a skip a number of years ago outside the Hospital at Halle University following a clearout of an attic.

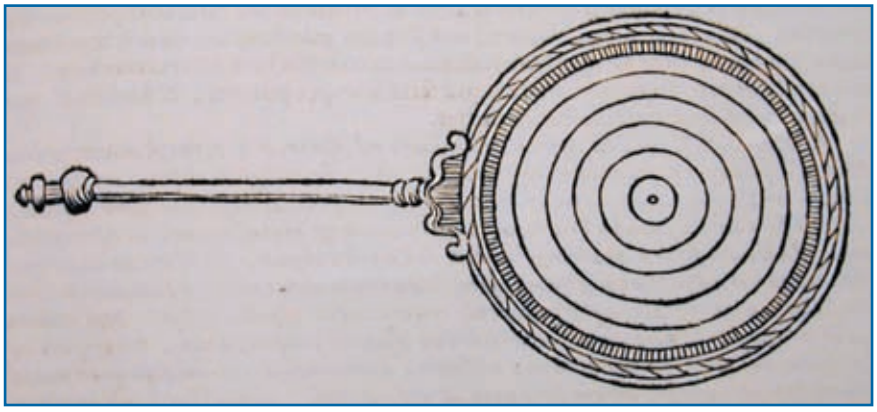
After1875 all trial and prescription lenses were designated in dioptres to overcome the confusion of lenses being measured in different focal lengths such as English, Parisian, Prussian and several other "inches".

Richard Keeler, Museum Curator
rkeeler@blueyonder.co.uk

The trial frame box

An illustration: The Spectacle Seller"

An early trial case



Zahn's polyspherical trial frame

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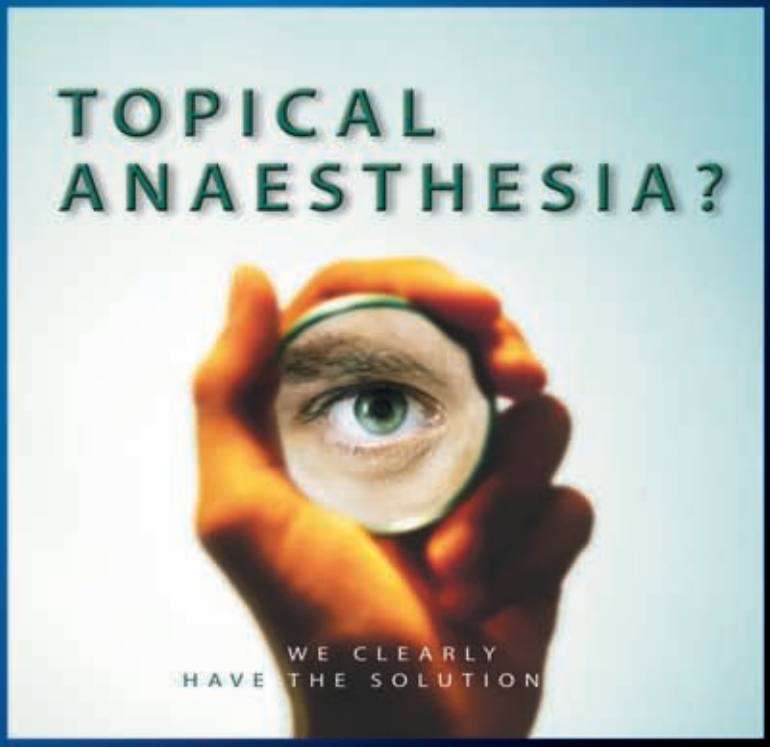

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Article 14

On Monday 21 January 2008 I was appointed as a Substantive Consultant Ophthalmologist to the Queen Elizabeth King's Lynn Hospital NHS Trust, Norfolk.

My achievement of this position in the NHS would not have been thinkable had I not been successful in my application to the Postgraduate Medical Education and Training Board (PMETB) through Article 14 in July 2005.

First of all, I should say that when the PMETB was established as a statutory body and took over the certification role for specialist training, many doctors in the UK were deeply dubious and cynical about its willingness to introduce doctors into the GMC specialist register through Article 14.

However, I believe that the whole process has proven to be fair regardless of the early teething phase that the PMETB experienced. Needless to say, there is now strong evidence that more doctors in the UK are gaining access to the specialist register through Article 14.

Unlike its predecessor (the Specialist Training Authority), PMETB is independent of the royal colleges, although it has to rely heavily on the hard work and goodwill of the colleges.

I have to say that it was an uphill exercise and a time-consuming task to put together the application, which amounted to three folders of information. I had to collect a huge amount of data that included an up-to-date CV, log books and evidence of clinical training/experience, qualifications and examinations, appraisals, portfolio of training and continuing professional development and six references, each of which required a 14-page thorough, structured report.

I would like to pay a tribute to all my consultant colleagues at the Norfolk & Norwich University Hospital and Birmingham Eye Centre who supported my application.

Now having been one of the first doctors in the UK to be awarded entry into the specialist register through Article 14 and subsequently achieving my utmost ambition of becoming a substantive consultant in the NHS, I look back at the whole marathon process and am positive it was worthwhile.

Alaeddin Faris Hatoum

College of Optometrists' Diploma in Glaucoma for Optometrists

Did you know your hospital optometrists (and community optometrists) can study for and take Diplomas in Glaucoma under the auspices of the College of Optometrists?

These are examinations which have been established for some years now in conjunction with glaucoma specialist representatives from the College. Glaucoma A is aimed at the optometrist who wishes to be competent in glaucoma detection and thereby have the experience and knowledge to work in a referral refinement scheme.

Glaucoma B aims to place the optometrist at a level of competence, theoretical and practical, suitable for working in a shared care management scheme. Glaucoma B cannot be taken without possession of glaucoma A.

Both Diplomas are acquired via examination consisting of three parts, assessment of a clinical portfolio, submited in advance by the candidate (similar to those required for our exit assessment), including a one hour viva on the same, a written examination and an OSCE style clinical examination. All assessments are undertaken by two examiners, one from the College of Optometrists and one glaucoma specialist ophthalmologist.

The standard expected is high and optometrists who have taken and passed the Diplomas agree that the preparation work and the process of taking the Diplomas has given them valuable additional knowledge and skills for their clinical activities both inside and outside the hospital environment. Optometrists can access details of the diplomas via their college website, Ophthalmologists interested in the syllabus and the format of the examination can obtain copies from *stephen.vernon@nuh.nhs.uk*

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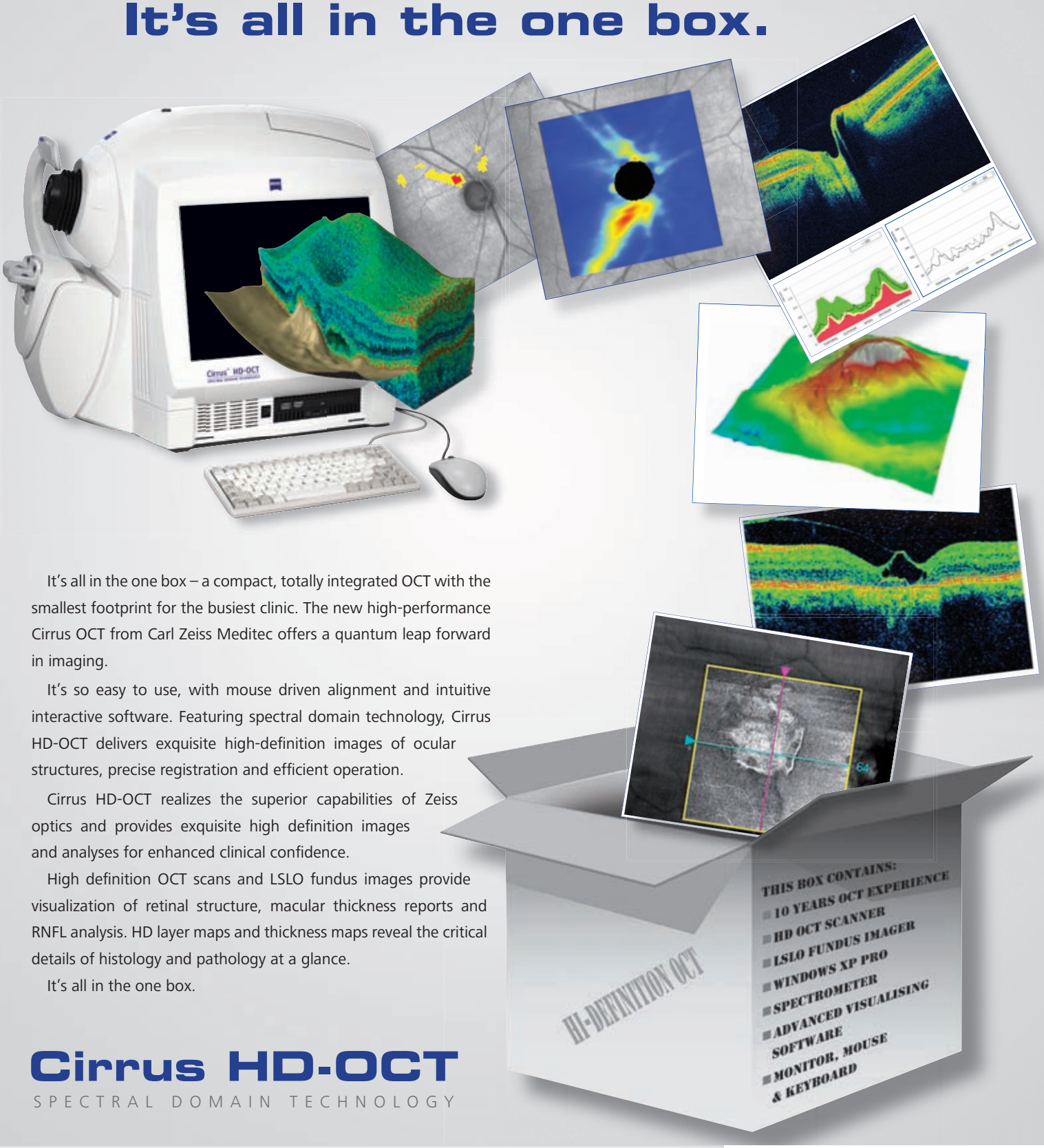

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Revalidation

– what will it mean for me?

In the aftermath of the Bristol enquiry and the cases of Rodney Ledward and Richard Neale, the Chief Medical Officer's paper "Supporting doctors, protecting patients" made a series of recommendations including regular appraisal for career grade doctors and a periodic check on the continuing fitness of doctors to practise. For the first time, competence was to mean something more than absence of evidence of incompetence.

The General Medical Council's (GMC) plans for a certificate of fitness to practise (revalidation) based on a cycle of five satisfactory annual appraisals were suspended in 2005 when they were criticised as ineffective by Dame Janet Smith in her report into the case of Dr Harold Shipman. The government then commissioned two major reviews of the regulation of health care professions by Sir Liam Donaldson (the medical profession) and Sir Andrew Foster (other health care professions). The reports made similar recommendations about the structure and function of the professional regulatory bodies, which are the subject of legislation currently going through Parliament.

The Donaldson Report, entitled Good doctors, safer patients contained detailed recommendations about the process of revalidation, most of which have been adopted in the 2007 White Paper "Trust, assurance and safety."

Revalidation will have two components, termed Relicensure (RL) and Recertification (RC) both of which will operate on a five-year cycle. RL (administered by the GMC) will apply to all practising doctors and represents the right to remain on the medical register. It will depend on workplace-based appraisal and will include peer and patient feedback. RC (designed and administered by the medical Royal Colleges and specialist societies) will apply only to doctors who are on the Specialist Register or GP Register and represents the right to remain on that register.

The separation of revalidation into RL and RC ensures that it is not a "one size fits all" process and reflects the diversity of medical practice. However, it also raises some important questions which have yet to be answered fully, for instance:

- How do RC and RL inform each other for the doctor who must undergo both?
- How will the specialist skills of staff and associate specialist doctors be assessed?

Recognising the need for a measure of fitness to practise which will command public confidence without creating a bureaucratic monster, the white paper states that revalidation must be "cost-effective, proportionate and an effective use of professional time away from patients".

The medical Royal Colleges have all concluded that the best (and probably the only feasible) vehicle for RC will be an electronic portfolio. Trainee ophthalmologists have been using an electronic portfolio, which is linked to the College's on-line curriculum since August 2007. An electronic portfolio to support RC will need to reflect the fact that there is great diversity of practice amongst ophthalmologists and it will not therefore be possible to map practice to a single curriculum.

The details of what may or must be included in an electronic portfolio for RC will be worked out in consultation with College members and tested carefully – a project which will start this year. To begin with, it will be limited in scope and will cover areas of practice for which there is already good data on process and outcomes (e.g. cataract surgery). Wherever possible, it will use information that is already being collected as part of routine clinical care. The mechanism for recording CPD activities will be improved and the portfolio will provide links to electronic educational resources (e-learning). We propose that career grade ophthalmologists who are not on the specialist register (including those who work entirely outside the hospital eye service) should have access to the electronic portfolio and its associated educational resources, whether or not this is compulsory for their revalidation.

There are a number of questions on which we will be soliciting feedback from members, for instance:

- Is there a core component of knowledge and skills which all practising ophthalmologists must possess regardless of their degree of specialisation and the environment in which they practise? If so, what should it include and how should it be assessed?

- What is the best way of quality assuring skills in rapidly evolving, highly specialised areas of practice where optimal treatment protocols may be uncertain?

The future of professional self-regulation depends on developing a process of revalidation of medical practice which will command public confidence, but it is this College's aim that recertification should be a mark of professional pride and self-confidence as well.

Richard Smith
Vice President and Chairman of the Professional Standards Committee

SCIENTIFIC NEWS

We are pleased to announce that the new Programme and Seminars Secretary is **Parwez Hossain.** He can be contacted at *events@rcophth.ac.uk*

UK Retinopathy of Prematurity Guidelines

Please note that the above was posted on the College website in December 2007 *http://www.rcophth.ac.uk/about/publications/*

Ophthalmic genetic tests available to UK clinicians

There was considerable interest in the notice contained in the Winter 2008 issue on a specific genetic test and College News has received details of many others. It has therefore been decided to codify the tests available in the members section of the website.

The Quality and Safety Sub-committee

The Winter 2007 issue carried an article by Simon Kelly which called for examples of good clinical practice or quality improvement initiatives. This is an opportunity for members to share their successes and help shape Department of Health policy. Email *penny.jagger@rcophth.ac.uk.*

The Thomas Pocklington Trust

Non medical eye clinic support services are valued for the information, advice and support offered to patients. The Trust commissioned research into the impact and development of these services which found that, frequently, insufficient records were available to evaluate, demonstrate or refine the work of services.

Practical guidelines for record keeping have now been produced. They draw on experiences of what works to provide templates for records, and guidance on their use, and aim to ensure information is collected that may improve services. The guidelines and the original research are relevant to those who manage, work in or with eye clinic support services, and can be downloaded from *www.pocklington-trust.org.ok.*

THE BRITISH OPHTHALMIC SURVEILLANCE UNIT

(BOSU) continues to survey uncommon ocular diseases of public health and scientific importance. In 2008 there will be some new conditions on the yellow cards which are sent to all consultants and specialists each month:

Cicatrising Conjunctivitis and Stevens Johnson Syndrome

Cicatrising conjunctivitis is defined as all newly diagnosed patients with conjunctival inflammation associated with scarring, except, if there is a history of trachoma, an acute infectious membranous conjunctivitis or trauma (chemical, radiation, heat, mechanical, surgical) or when there are un-inflamed eyes.

Coat's Disease

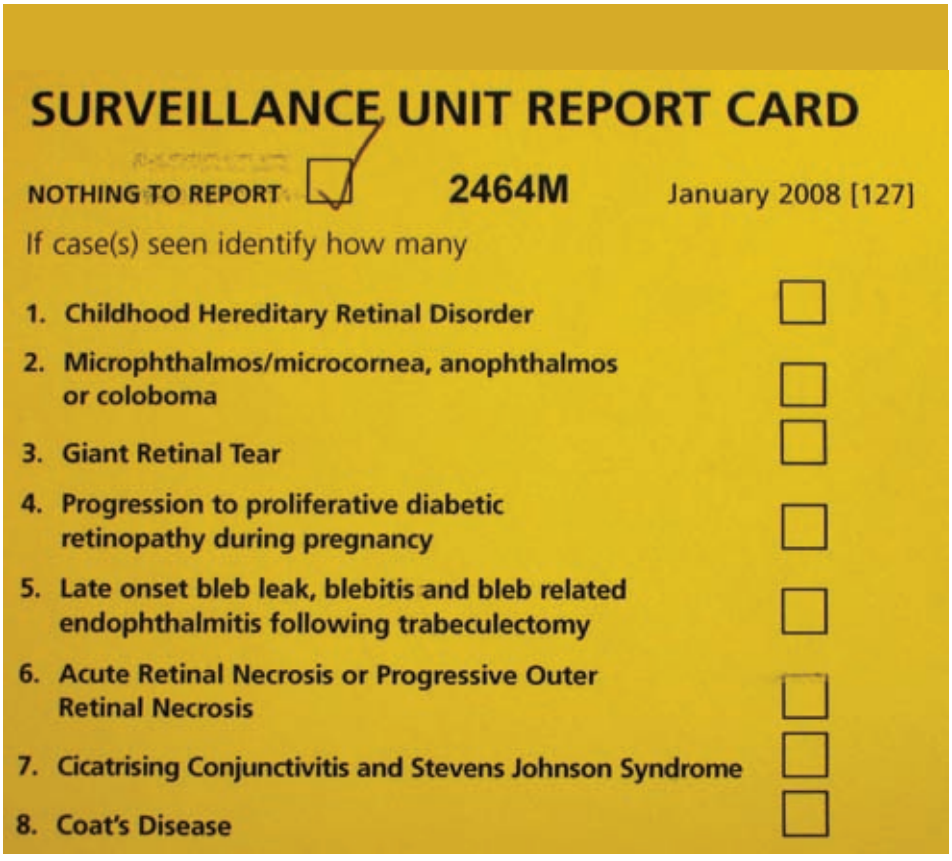
Please report any case of Coat's disease that has idiopathic retinal telangiectasia with intra-retinal or subretinal exudates and without signs of retinal or vitreal traction, occurring under 16 years of age.

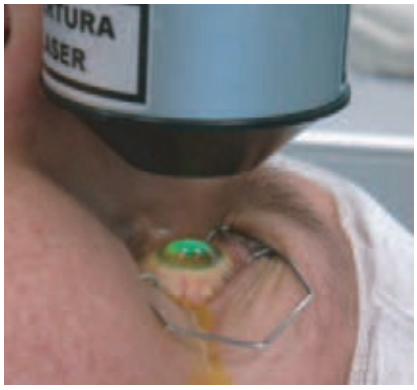
Ocular Sebaceous Carcinoma in the United Kingdom: epidemiological study of incidence and outcomes.

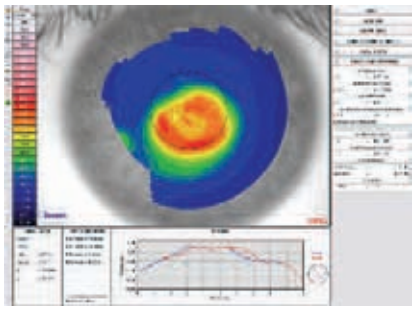
(from February 2008)

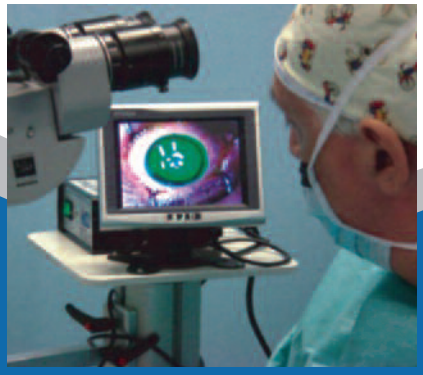
epidemiological study of incidence and outcomes. This is defined as "any new patient with a histopathologically confirmed (biopsy-positive) diagnosis of sebaceous cell carcinoma arising from the ocular surface or eyelid".

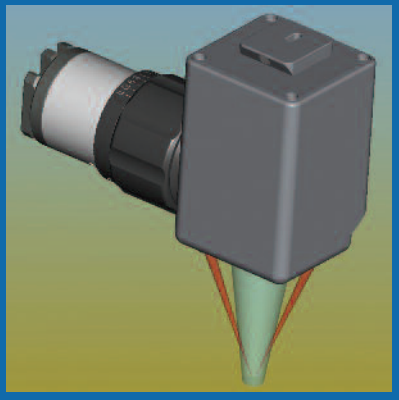
If you require any further information on the unit or are interested in conducting a study of your own please contact Barny Foot *(BOSU@rcophth.ac.uk)*
Please return the cards - even if there is nothing to report.











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Making light work

The CBM Vega Cross Linking System for Keratoconus Treatment has been designed to provide you with optimal control, security and peace of mind for all your Cross Linking procedures.

Used in conjunction with RICROLIN CE sterile single dosage Riboflavin, the CBM Vega X Linker provides controlled exposure of UV A light over a variable treatment zone.

The solid state diode emits UV-A rays peaking at 370nm. This, combined with an innovative optical system ensures homogeneous distribution of UV A light across the entire treatment area.

The unique and fully flexible conterbalanced operating arm provides you with ultimate control, ensuring the optimal operating position for each and every patient. This, combined with real time images from the on board colour camera allows precise and simple focussing.

The integral monitor and timer provide you with an up to the minute check on treatment data for greater control.

CBM Vega X Link

Key features and benefits

- Footswitch
- Fixation point
- Fully flexible counterbalanced operating arm gives you precise control for every treatment.
- Optimal working distance for easy operation
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- 2 focussing LEDs
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For additional information please contact;
Carleton Ltd, Pattisson House, Addison Road, Chesham, Bucks, HP5 2BD
Tel: 01494 775811 • Fax: 01494 774371
Carleton@carletonltd.com • www.carletonltd.com

EDUCATION AND TRAINING

Training the Trainers Courses

Spring

Day 1	Wednesday 2 April 2008 - What to teach and How to teach
Day 2	Tuesday 22 April 2008 - Improving teaching skills and Feedback and appraisal
Day 3	Friday 13 June 2008 - Assessment and Problem Solving

Autumn

Day 1	Tuesday 23 September 2008 - What to Teach and How to Teach
Day 2	Tuesday 7 October 2008 - Improving teaching skills and Feedback and appraisal

Please visit www.rcophth.ac.uk/education for more details

Travel Awards and Fellowships

AWARD	AMOUNT	CLOSING DATE
Patrick Trevor Roper Undergraduate Award 2008	Two awards of £550 each	6 June 2008
Sir William Lister Travel Award 2008	c. two awards £400-£600 each	3 October 2008
Dorey Bequest Travel Award 2008	c. two awards £400-£600 each	3 October 2008
Pfizer Ophthalmic Fellowship 2008	One award of up to £35,000	24 October 2008
Ethicon Foundation Fund 2008	Four to six awards of c. £400-£800 each	7 November 2008

Information and application forms for all awards are available on the College website: www.rcophth.ac.uk/education/travelawards

Continuing Professional Development
- *RCOphth/AAO Compass initiative*

There are still a few spaces left for members who are registered with the College's CPD to access Compass, an online teaching resource produced by the American Academy of Ophthalmology (AAO). It contains self assessment questionnaires and you can award yourself CPD points (category C) for any time you spend on the work, at a rate of one point per hour of study.

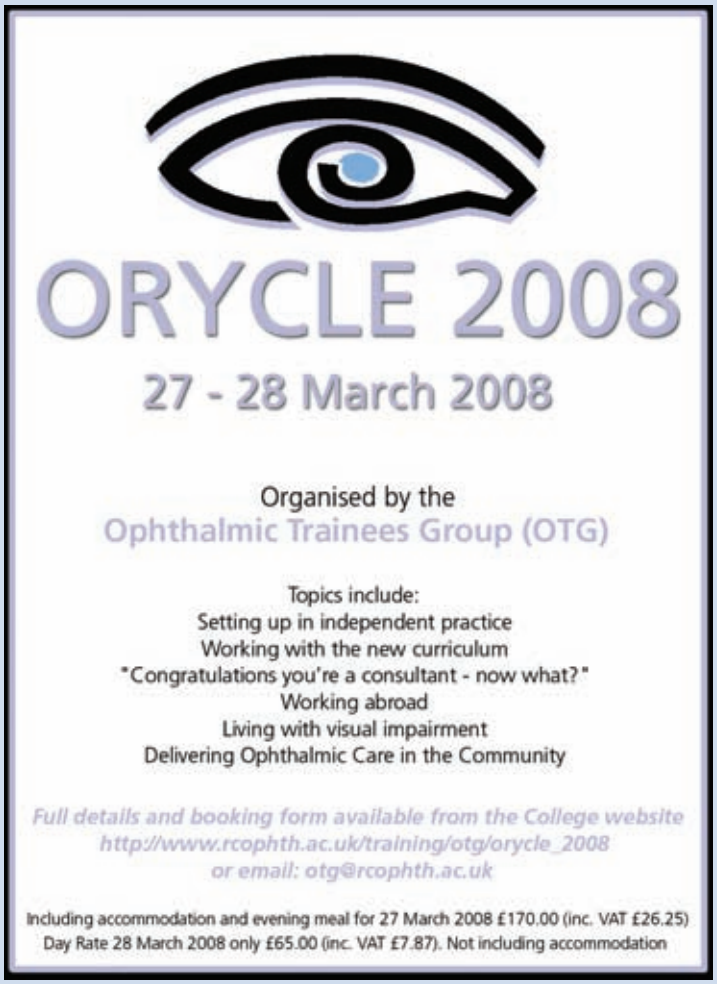
This is a free service for the first 500 members who sign up in the trial period. We will seek feedback from participators in due course.

If you are not already part of the College's CPD Programme please register via the College website www.rcophth.ac.uk

To access Compass please email your membership number, full name and grade to *compass@rcophth.ac.uk*

Cosmetic Surgery Interspecialty Committee (CSIC) – *Senate of Surgery*

Following a call for a College representative for the above (College News - Winter 2007) Mr Naresh Joshi has been appointed.



Excellent Single Use products

Brilliant Peel

The latest product from Fluoron, Germany. A membrane dye that selectively stains the I.L.M.

Fully licensed, non toxic and exhibiting a stable concentration, this product this is the ideal aid for successful membrane peeling. Samples available.

Geuder 23G

We are pleased to announce the arrival of ErgoLine 23G instruments and a convenient 23G Trocar/Port system from Geuder, Germany.

Ergoline Forceps & Scissors feature removable and interchangeable tips. 20G also available.

Altomed Coaxials

A perfect tip for every case. The Altomed Coaxial I/A handpieces are available with a choice of six tip configurations and give you reusable tip quality with the convenience of disposability.

Contact customer services to request a free sample.

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College Seminar Programme 2008

All seminars take place at the College, unless otherwise stated

Intravitreal Therapies
1 April
Chaired by: Mr Yit Yang

Intravitreal Therapies
18 June
Chaired by: Miss Clare Bailey

Retinal Imaging Course
The Institute of Physics, London
10 - 11 July
Chaired by: Mr Yit Yang

Public Health Ophthalmology
4 September
Chaired by: Mr Nick Astbury/ Mr Andrew Cassels-Brown

Intravitreal Therapies
25 September
Chaired by: Professor Sue Lightman

Oculoplastics
The Institute of Physics, London
30 September
Chaired by: Mr Tony Tyers

Glaucoma Surgery Masterclass
The Institute of Physics, London
10 October
Chaired by: Mr Peter Shah

Re-Licensing & Re-certification
14 October
Chaired by: Mr Richard Smith

Diabetic Retinopathy
24 October
Chaired by: Mr Victor Chong

The Elizabeth Thomas Seminar on AMD
Venue: The East Midlands Conference Centre
28 November
Chaired by: Mr Winfried Amoaku

Please visit www.rcophth.ac.uk/scientific/seminars for further details.

College Skills Centre Programme 2008

Twelve Basic Microsurgical Skills Courses are planned for 2008 and details are on the website. Please visit ***www.rcophth.ac.uk/about/skillscentre/*** for more details. Additional courses are listed below and these take place at the College, unless otherwise stated.

Oculoplastics HST/OST Study Day
4 April
Chaired by: Mr Bijan Beigi/ Miss Jane Olver

Intermediate Phacoemulsification Course
9 May
Chaired by: Mr John Brazier

Oculoplastics HST/OST Study Day
4 July
Chaired by: Mrs Sally Webber/ Miss Helen Herbert

Medical Retina HST/OST Study Day
29 September
Chaired by: Mr Larry Benjamin/ Miss Susan Downes

Paediatric HST/OST Study Day
2 October
Chaired by: Mr Ken Nischal/ Mr Christopher Bentley

Intermediate Phacoemulsification Course
10 November
Chaired by: Mr John Brazier

Oculoplastics HST/OST Study Day
26 November
Chaired by: Miss Sally Webber/ Ms Ruth Manners

VR HST/OST Study Day
5 December
Chaired by: Mr Paul Sullivan/ Mr Larry Benjamin

Annual Congress - including Ball

20 – 22 May 2008
The Arena & Conference Centre, Liverpool

Seniors' Day 2008
12 June
Please note the date, details to follow.

Other events 2008

19 March
Seventh Annual Eye Surgery Update,
The MDA Clinic, Cardiff
laservision@mdaclinic.co.uk
www.mdaclinic.co.uk

9 - 11 April
Tropical Ophthalmology Course
International Centre for Eye Health, London School of Hygiene and Tropical Medicine, London
shortcourses@lshtm.ac.uk

7 - 10 May
SOI Società Oftalmologica Italianà
13th Annual Joint Meeting on Cataract and Refractive Surgery
Naples
sedesoi@soiweb.com

19 May
UKISCRS Satellite Meeting 2008
Avoiding Risk, Improving Outcomes in Cataract Surgery
The Arena & Conference Centre, Liverpool
ukiscrs@onyxnet.co.uk

4 June
NEOS & MOS Joint Summer Meeting - retina
Sheffield City Hall
executive@neos.org.uk
www.neos.org.uk

16 - 28 June
Final Membership (III) Refresher
Moorfields Eye Hospital
courses@moorfields.nhs.uk

18 June
Trainees Symposium of British Oculoplastic Surgery Society
Northern Stage, Newcastle upon Tyne
cy.thirlaway@nuth.nhs.uk
bopss@ncl.ac.uk

19 - 20 June
British Oculoplastic Surgery Society Annual Scientific Meeting Northern Stage,
Newcastle upon Tyne
cy.thirlaway@nuth.nhs.uk
bopss@ncl.ac.uk

28 June - 2 July
World Ophthalmology Congress
Hong Kong
info@woc2008hongkong.org
www.woc2008hongkong.org

6 - 8 July
Oxford Ophthalmological Congress
The Oxford Playhouse
www.oxford-ophthalmological
o_o_c@btinternet.com

7 -11 July
Planning for VISION 2020
International Centre for Eye Health, London
shortcourses@lshtm.ac.uk

11 - 12 July
Bicentenary Celebrations
West of England Eye Unit/Infirmary, Exeter:
All former members of staff warmly invited to attend
john.jacob@rdeft.nhs.uk

3 - 5 September
38th Cambridge Ophthalmological Symposium - Transplantation
St John's College, Cambridge
Chairman: Professor Douglas Coster
b.ashworth@easynet.co.uk

12 September
4th Vision Research meeting
A full day academic meeting focusing on the science behind ophthalmology. Themes: Development, Structure and Myopia; Tumours and Tolerance; Infection and Immunity
University of Bristol, Health Trust Education Centre
www.bristol.ac.uk/clinicalsciencesouth/ophthalmology/vision/
maggie.cook@bristol.ac.uk

18 – 21 September
DOG-Kongress
Estrel Hotel, Berlin
www.dog2008.org

9 - 11 October
British Isle Paediatric Ophthalmology and Strabismus Association Annual Meeting
Sheffield Town Hall
Samantha.Howard@sth.nhs.uk
www.biposa2008.org/

13 - 14 November
UKISCRS Annual Meeting
The Dome, Brighton
ukiscrs@onyxnet.co.uk

21 November
Symposia on: Contact Lenses, Corneal Infections & Keratoconus
The Medical Contact Lens & Ocular Surface Association (MCLOSA)
The Royal Society, London, UK
Kersley Lecturer: Peter McDonnell (Birmingham, UK)
mclosa.admin@gmail.com
www.mclosa.org.uk

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